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ABSTRACT

The paper discusses some of the basic issues involved in providing child identification, screening, and assessment services for preschool emotionally disturbed children. Attention is given to the public school's concerns as to what constitutes an emotional disorder, what role the school district can take in finding and assessing children with emotional disorders, and what some of the current approaches are in that regard. Recommendations are also given as to some ways of improving screening and assessment methods with preschool emotionally disturbed children. (Author)

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DESIGNING A SPECIAL EDUCATION CHILD STUDY SYSTEM FOR PRESCHOOL EMOTIONALLY DISTURBED CHILDREN

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Cambridge, Minnesota

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This paper is written from my perspective as a regional consultant in the early education of the handicapped. In that capacity I have provided program consultation, in-service, dissemination, and evaluation services to a variety of agencies serving preschool handicapped children in Central Minnesota. The primary focus has been with the public school systems, many of which are just in the process of developing special education services for preschoolers, especially for children who are four or five years old. Questions and concerns which come to my attention on the subject of preschool services for emotionally disturbed children cross through policy, administrative, and service consideration. In the process of dealing with these various concerns it has become obvious that questions of how to screen for or assess emotional disorders cannot adequately be discussed without first addressing more general but pervasive administrative, policy, and attitudinal concerns. Consequently, some of those concerns will be discussed first in this paper with the hope that doing so will help in the understanding of the total issue of child study services for emotionally disturbed preschool children.

Preliminary Questions

I do not pretend to have complete answers to the questions below. Rather, I am stating them as an expression of what I hear from the field. In addition, I believe these are questions which need to be raised and discussed, even if answers are not readily available.

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Question--What constitutes an emotional disorder?

This question is a necessary one for the public school system not just from a clinical diagnostic consideration; but also from an administrative eligibility concern. Administrators have expressed to me "some people want us to serve every shy kid in the county." Emotional behavior in early childhood does not fit well into some of the typical developmental concepts; consequently, approaches utilizing "a significant lag", while often helpful in other areas of child behavior, are less applicable in the area of emotional behaviors. Concepts of disturbance, significant behavior problems, or disorder are more commonly applied. The multiplicity of areas which can come under the consideration of emotional behaviors is also quite extensive, and to my mind more complex than what one normally considers under such areas as intellectual development, speech and language, or sensory-motor development. For example, one can consider areas of peer, family and social relations, cognitive functioning, emotional affect, self-concept and self-control, activity level, and body relations all as legitimate domains of emotional behavior, at least as one would view those behaviors from an understanding of personality. Each one of those areas in turn can present a large variety of concerns. The following is a list of early childhood emotional development concerns, any one of which might be the basis for consideration of providing special education services: aggression, hostility, withdrawal, interpersonal discomfort, uncommunicative, dependency, fears, absence or confused role models, possible child abuse, anti-social behavior, cognitive confusion, irrational, hallucinatory, disoriented, depression, anger, anxiety, lack of affect, excessive fears, low confidence, uncertain sense of identity, attention-seeking, over-sensitive, insecurity, self-blame, stubbornness, uncontrolled anger, discipline problems, impulsive, hyperactivity, hypoactivity, enuresis,

low energy level, serious eating problems, excessive physical complaints. One no longer has to wonder why this area of child development has been confusing to staff in special education systems.

Question--Do we as a school district have responsibility for serving the emotionally disturbed preschool child?

This question really is two-fold; first there is the issue of what degree and type of emotional disorder is eligible for services. Secondly, given an eligibility for services, does the school district need to get into the supportive service areas such as parental counseling, child adjustment consultation, etc. Federal and state (Minnesota) law provides the basis for serving the emotionally disturbed child. The appropriate section of Federal Law, 94-142, is as follows:

94-142 121a.5 Handicapped children

(8) "Seriously emotionally disturbed" is defined as follows:

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

(A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

(C) Inappropriate types of behavior or feelings under normal circumstances;

(D) A general pervasive mood of unhappiness or depression; or

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes children who are schizophrenic or autistic.

The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

M.S. 120.03 Handicapped Children Defined

Subdivision 3. Every child who by reason of an emotional disturbance or a learning disability, or a special behavior problem, needs special instruction and services, but who is educable, as determined by the standards of the State Board is a handicapped child.

Head Start programs also include children with emotional disturbance as being eligible for services. For reporting purposes Project Head Start defines emotional disturbance as follows:

"A child shall be considered seriously emotionally disturbed who is identified by professionally qualified personnel (psychologist or psychiatrist) as requiring special services. This definition would include but not be limited to the following conditions: dangerously aggressive towards others, self-destructive, severely withdrawn and non-communicative, hyperactive to the extent that it affects adaptive behavior, severely anxious, depressed or phobic, psychotic or autistic." (Transmittal Notice Annoucement of Diagnostic Criteria for Reporting Handicapped Children in Head Start, OCD-HS, September 11, 1975.)

In terms of what services should be provided by the educational system for the preschool emotionally disturbed child, it is not the purpose of this paper to address that question. Suffice it to say that this question does interfere with child study processes and that clear answers do not exist, at least in Minnesota, as to what constitutes appropriate special education services for the preschool emotionally disturbed child, and which services, if any, are more the responsibility of other agencies.

Question--Do we really need to label a preschool child as emotionally disturbed?

Labeling is conducted for at least two purposes in child study processes. First, a diagnostic classification is necessary for administrative, child count purposes. Secondly, there is the general professional opinion that a diagnostic classification can assist in determining the most appropriate methods of intervention. In terms of administrative requirements there is inconsistency between Minnesota state reporting and federal reporting in that Minnesota allows for the non-categorical grouping of preschoolers; and many children are determined eligible for services locally on a classification such as developmentally delayed or special learning and behavior problems.

A review of the December, 1978 categorical child count from school districts throughout Minnesota indicates that only 122 of the approximately 4,000 handicapped preschool children were classified as emotionally disturbed. This constitutes approximately 3% of the preschool handicapped population as compared with a national handicap incidence estimate of children with emotional disorders constituting approximately 17% of special education children.

Figures from Head Start records as to the number of preschool children classified as emotionally disturbed in the state of Minnesota display quite a similar pattern. Of the approximately 570 handicapped children being served in Head Start in Minnesota in the school year 1978-1979, 26 were classified as emotionally disturbed. This constitutes approximately 4.5% of the handicapped population. The figures by school district and by Head Start program also show considerable variation and no relationship to what might be considered general estimates of incidence. A number of programs which do utilize emotional disturbance as a diagnostic category list as high as 20% of their preschool handicapped population in that category while the

vast majority of programs around the state do not list any of their preschool handicapped children as emotionally disturbed.

Federal child count reporting, however, does not have a non-categorical preschool classification, nor does it have a classification titled behavioral problems. Consequently where preschool systems are serving emotionally disturbed children the local administrators either need to count those children in the emotionally disturbed category, or somewhat fudge on categorical classification and count those children as learning disabled or even in some cases language handicapped. The labeling process for federal child count, however, does not need to nor does it usually have any impingement on the child or parental and staff perceptions of the child. The extent to which the local education agency utilizes categorical classifications in their discussions and planning with preschool children as opposed to relying primarily on child descriptions of developmental lags, behavioral difficulties, etc., then appears to be able to be determined locally on the basis of whatever policies and professional opinion exists.

Question--Isn't intervention with preschool children having emotional disorders really an invasion of parental responsibilities?

For various reasons working with children and their families in the area of emotional growth has been more sensitive than has working with other conditions. However, the sensitivity of an issue is insufficient grounds for denying services. As with all areas of preschool educational services the parents have the right to those services and the right to refuse those services. Consequently, the provision by the public school of appropriate preschool special education services is ethically appropriate. As with other conditions, of course, maximum parental participation in the development of the education plan and the on-going parental prerogative of always being able to remove their child from the program of course needs to be emphasized.

Locating the Emotionally Disturbed Preschool Child

The usual basic child find procedures certainly apply to the area of preschool emotional disorders, and need not be reviewed in detail here. These include public information efforts, referral relationships, and screening programs. Public information materials should be reviewed to see if they allow for an interpretation by the reader that it is okay to make a contact with a special education system because of a concern regarding some emotional behavior. Similarly, referral relationships, presentations to other staff, and forms utilized by outside agencies to make referrals should allow for a referral on the basis of an emotional consideration. Social service and mental health agencies are the more common sources of referral of preschool children on the basis of emotional disorders, although public health programs and family physicians are also a significant referral resource in this area. In contacts the author made with both the public school and Head Start programs which were serving a higher number of emotionally disturbed children it was apparent that those programs had closer working relationships with mental health facilities. Some of the Head Start programs, in particular, not only had close referral relationships with mental health programs, but contracted for consultation and observational services; and often worked jointly with them in providing services for an emotionally disturbed child and that child's family.

Preschool screening programs constitute an effort of child find which is currently very active in Minnesota, at least with three and four-year-olds; and which in turn often lacks a basic component for the identification of emotional difficulties. It is perhaps best to think of a screening system as a filtering process. Consequently, a thorough design of the screening process has to have in mind what will happen subsequent to that process. More

specifically, if a local agency is screening for emotional disorders as part of its overall preschool child screening, an assessment system for emotional disorders has to be established, the components of the actual preschool program to serve children assessed as having emotional disorders has to be established, knowledge of and means to refer to outside mental health resources needs to be established, and a monitoring system on the effectiveness of services subsequent to the screening also needs to be in order. Only with a clear understanding of the processes and services available subsequent to the screening, and methods established for accessing those services, can the local educational agency adequately design its screening program.

A determination needs to be made of the personnel needed for screening for emotional disorders. There are several levels of involvement which personnel may have in the screening system, and decisions regarding personnel should be in reference to those various levels of involvement. For example, consultation may be provided by various personnel in the development of the screening system itself. Consultation may also be provided on individual cases seen during the screening process. A more extensive level of involvement of course is the actual participation directly in the screening both in child observation and testing, and in parent interviews.

A school system will have varying professional resources within its own staff and may need to reach outside of its agency either on a contractual basis or an informal sharing of responsibility basis with other agency staff. Typically, the school psychologist and school social worker can participate in one or more of the above levels of involvement. The speech clinician and school nurse may also have some specialized skills in certain aspects of emotional disorders. Utilization of the mental health center staff and county or other agency social service staff may also be necessary if the

school staff consider themselves insufficiently experienced to take responsibility for various aspects of screening for emotional disorders.

In actuality most of the preschool screening programs in Minnesota, whether they are operated by the public school system, Head Start, or a public health system, do not utilize personnel from mental health resources nor school psychologists or school social workers to any significant degree in any aspects of the screening program. Again, where the occasional exceptions to this trend have occurred, there has been an increase in screening for and identification of emotional difficulties.

When the personnel resources have been sufficiently identified, the next logical step is to look at the criteria to be utilized in determining whether there is sufficient concern to refer the child for a more in-depth screening and/or assessment. A basic premise which I suggest at this time and one that I have found useful in a number of preschool settings is that considerable information already exists in data gathered for preschool screening, and that this data can be utilized in screening for emotional disorders. The health history questionnaire which parents of all of the children are asked to fill out prior to the screening contains a large number of items which have relevance to determining whether or not significant emotional difficulties may exist. Appendix A contains those items in the Minnesota Preschool Health History Questionnaire which have been found useful in a number of settings in more accurately identifying those children who may be experiencing emotional difficulties. In one series of screening sessions, with approximately 260 four-year-olds, utilizing a cut-off criteria of four or more behavior items checked as a concern by the parent, approximately 10% of the population were screened as possibly needing further assessment and programming for emotional disorders. Subsequent assessment procedures resulted in 20 of the original 26

being referred for either special education, parent education, or mental health services. Subsequent to this effort, which was utilized in the school year 1977-1978, another special education cooperative serving four school districts adapted and refined the criteria (see Appendix B). The modifications resulted in a slightly higher number of referrals for discussion of emotional concerns in the exit interview of the screening process, and approximately one-third of those originally identified in the screening criteria (10 children) were referred for assessment purposes subsequent to the exit interview. The point is not that these items or the cut-off points used may necessarily be the most accurate; rather that significant information does exist in those forms, and should be utilized to its fullest before deciding to ask a lot of other questions of the parent.

Observational information obtained during the screening process is also another existing source of information regarding emotional behavior. Experienced screening staff are aware that the screening setting may be a unique experience for the child and consequently the behavior experienced there can in no way be assumed to be typical. With that caution in mind, the training of the existing screening staff to note unusual or inappropriate behaviors, and the establishment of cut-off criteria on the basis of behaviors, is rather easily designed. Some developmental screening tests already have such checklists and criteria (e.g., D.I.A.L., Mandell & Goldenburg, 1972, and C.I.P., Zehrbach, 1976) incorporated in them, whereas others (e.g., Denver, Frankenburg & Dobbs, 1970) totally lack such checklists. One large suburban school district in Minnesota utilizes the Developmental Profile (Alpern & Bole, 1972). Although this particular screening instrument does not have a scale specifically designed for emotional behaviors, because the screening process is one of a sustained interview with the parent the personnel involved in screening

in this district indicate that they establish a sufficient rapport with the parents to elicit parent concerns regarding their child's emotional behavior. Further discussion with the screening staff in that district does suggest that they are able to identify a significant number of children having emotional difficulties of a mild to moderate nature through this process, and program for them accordingly.

It is my opinion that the information able to be gathered from the health history questionnaire and observational data is sufficient to provide for a determination of whether assessment is appropriate, when that information is discussed and refined with the parent through an exit interview. It has to be kept in mind that screening is just that and not a process by which details of a child's behavior are well determined, nor is it a determination of significant developmental lags or disturbance. That is the purpose of an assessment, and reassurance to a parent of the screening's purpose and limitations can often assist in providing the opportunity for the parent to make an appropriate decision as to whether or not they wish their child to be assessed. A well conducted exit interview, then, can clarify the concerns raised in the health history questionnaire and in observational material; and an experienced interviewer usually is in a position of having sufficient knowledge to make recommendations to the parent. If an educational system wishes to have more comprehensive screening in the area of emotional disturbances, then the inclusion of a more formalized screening inventory or questionnaire in the area of emotional disturbance can be undertaken. However, many of the questions involved in preschool emotional development inventories overlap considerably with information already gathered and it is likely that parents will become irritated with the amount of paperwork and duplication. Consequently, I do not recommend that an additional questionnaire be incorporated into the screening, but if that is

the preference of the school system, then such questionnaires as the Burks' Behavior Rating Scales (Burks, 1977), or the Minnesota Preschool Inventory (Ireton & Thwing, 1979) might be appropriate although these can also be incorporated into the assessment process.

If the person usually conducting the exit interview, which typically is a nurse, feels somewhat uncomfortable in reviewing concerns over emotional disturbances, then the utilization of another perhaps more appropriate professional for those interviews, or at least that portion of the interview covering emotional concerns, would be appropriate. This would typically be the school psychologist or school social worker. If it is decided between the parent and the exit interview person or exit interview staff that an assessment in the area of emotional development is appropriate, then, of course the parent should be totally advised as to what that assessment will involve.

Basic Concepts in Assessing Preschool Children for Emotional Disorders

The amount of information available to the staff conducting the assessment of course will vary depending upon whether a child has come through a screening procedure, referral from another agency, or through a contact from a parent. Consequently, the amount of background information necessary to obtain will vary accordingly. There are certain premises which have been important to me in a general understanding of the assessment process with young children possibly having emotional disturbance. The most important premise to my mind is that emotional behavior, especially at this age, is highly variable, with regard to time, circumstances, relationships, and roles. Consequently, an adequate assessment must reflect an awareness of that variability. This premise seems even more important in the area of emotional behavior than in other areas such as cognitive development, gross and fine motor, and speech and language.

Variability with regard to time suggests that several samplings of behavior are important, perhaps at different times of the day. Variability as to circumstances suggests that the child may perform quite differently when he or she is rushed, hot, tired, in an unfamiliar room, or with unfamiliar people, than he or she otherwise would perform. Consequently, noting of variation as to the circumstances and observations under differing circumstances is important. Variability of the child's behavior depending upon the existing relationships also is quite crucial. The child may perform quite differently depending upon whether he is relating primarily with his mother, father, teacher, sibling, or someone totally unfamiliar. Again, not only noting what a child is able to do, but with whom, is crucial. The roles which the child takes (in the assessment process) also should be noted. For example, if a child is asked to show some of the other children how to behave or accomplish something that child may do better or more poorly than if he is asked to imitate that same behavior in response to another child's direction. With these considerations in mind we can now look both at some of the traditional and more innovative methods of assessment.

A common traditional assessment model, still found in many diagnostic agencies as well as in some school system assessment teams, usually takes the following format. A case history is obtained, this including referral information as well as background information from the parent. Developmental and biological information is also obtained. Phenomenological information is the other major sphere of a traditional assessment model. This basically, for the preschool child, is a mental status examination which includes a diagnostic interview with the child, and sometimes with the child accompanied by the parent. In addition, psychological testing is usually incorporated, and some limited observational procedures. Traditional emotional psychodiagnostic methods

with a three or four-year-old often includes a Children's Apperception Test or a Thematic Apperception Test, a Rorschach, and drawings. Many psychologists also prefer including an individual intellectual assessment and some testing of organicity for a more comprehensive battery even if the initial referral did not suggest any intellectual or organic deficit. There has been a proliferation of new diagnostic instruments for the assessment of emotional disturbances in children over the past several years. Unfortunately, most of these have not been developed sufficiently for valid general use, and the majority concentrate their focus on children ages five and up. However, if the reader wishes to explore some alternative individual emotional assessment instruments, he or she may wish to read some of the reviews currently available on those instruments (Hirt & Genshaft, 1976; Katz & Jacobson, 1978; Walker, 1973).

The above methods certainly provide considerable information, and may suffice in many settings. However, school systems have some additional concerns and perhaps some additional opportunities to allow the assessment process to be more thorough and relevant to special education programming. These considerations are discussed in the next section.

A Modified Assessment Model for Preschool Emotionally Disturbed Children

Because of the factors of variability in emotional behavior in early childhood as indicated above, and the need for as well as general reliability of information from parents on their child's behavior, it is recommended that an assessment model for preschool emotionally disturbed children include three basic components. These components are an informant's (parent's) inventory, psychological testing, and an observational period of significant duration. It is further recommended that these procedures, to the best extent possible, be of a standardized and quantifiable design. This provides the grounds for a more precise determination of a child's needs and progress; and for decision-

making as to eligibility for services and program evaluation, considerations of significant importance to the school system.

There are a number of parent inventories currently on the market which are appropriate to the preschool emotionally disturbed child. It is not the purpose of this paper to review all of those inventories. A recent review of parent report measures (Humphreys & Ciminero, 1979) may be of interest to the reader in this regard. Three parent inventories which have been gaining popularity in Minnesota are the Burks' Behavior Rating Scales (Burks, 1977), the Minnesota Preschool Inventory (Ireton & Thwing, 1979), and the Personality Inventory for Children (Wirt, et. al, 1977). These not only allow a good means for parental input but also the basis for comparison of the parent's view of the child with other persons involved.

The difficulty encountered with the Minnesota Preschool Inventory is that it was normed primarily for children who would be entering kindergarten in the upcoming school year; i.e., those who would be five years old by September 1. Much of the preschool screening in Minnesota is now being directed at the population of children who will be four as of September 1, so that if they are in need of and eligible for special education services, they can be provided those services for the year prior to kindergarten. The Burks' Scales are normed on a small, selective population. However, they can be used with the three and four-year-olds. An additional appeal of these scales is that they have considerable face validity with parents, and the manual provides some general intervention recommendations based upon the individual child's test profile. The author's experience with the Personality Inventory for Children is that, because of its length and the number of test items referring to school related behavior, some parents are irritated by the test and reluctant to take it. However, in those circumstances where the parents are willing to

complete a lengthy true/false test, the results obtained from this test can be beneficial for diagnostic determination and program planning.

The third major component to a thorough assessment for the preschool emotionally disturbed child is that of an extended observation. School systems and Head Start programs do have this opportunity typically, either through the actual establishment of a diagnostic classroom or through the incorporation of that process into one of their regular preschool classrooms. There are several advantages to incorporating a diagnostic observation period into the assessment. First, this allows the observation of the child over a period of time so that behaviors which may have been unique to earlier testing situations may likely not be seen under a continued placement in an observational program. Secondly, an observational placement for as much as three to four weeks can allow assessment as to the child's learning styles and difficulties which may be caused in that learning because of emotional difficulties. This sort of useful information cannot be obtained through either informant or psychological assessment methods. Another advantage is that the diagnostic classroom placement allows the parent to both observe and participate in the assessment so that a much more refined and participatory assessment can be accomplished. A further advantage is that the placement in a diagnostic classroom allows the child to be observed in relationship to other children. This of course is quite important for educational assessment purposes in that the usual model of instruction for most children is a classroom placement. The child may perform quite differently in that sort of setting than on a one-to-one with an adult. This sort of arrangement also allows for much more thorough and confident determination of eligibility by whatever criteria the school district establishes.

It appears that most observational methods in preschool classrooms are of an informal nature. Staff will often note outstanding emotional behaviors,

compare findings with other staff members, and chart variations in those behaviors across settings and time. There are also a number of more formal preschool observation measurement systems (e.g., Aaronson & Schaefer, 1973; Pastor & Swap, 1978; and Wolfgang, 1976); but such approaches are not used extensively. Naturalistic observation methods in preschool settings appear to be coming primarily from early childhood and developmental psychology fields. Since most preschool programs serving the emotionally handicapped are supervised and staffed by persons from special education fields, it may take some time for the preschool staff to become acquainted with and utilize some of those observational models to any great extent.

Conclusions

It is hoped that some of the thoughts conveyed in this paper are of use to staff in educational agencies and other agencies in the process of developing and refining their child study systems for emotionally disturbed preschoolers. Some of the ideas conveyed may be relevant to the planning by school systems at this time, but perhaps less relevant to the development of child study systems by other than educational agencies. However, to personnel in those settings, hopefully the paper will provide some additional information as to what currently are the thoughts and needs of school systems regarding this aspects of program development. It has repeatedly been impressed upon me in my consulting that there is no one ideal method or system applicable to all or even most educational settings. Rather, the variability in design must significantly reflect local policy, administrative design, and level of skills availble. Correspondingly, it is readily apparent that the accuracy of screening and assessment methods and instruments is sufficiently limited across all agency settings to suggest that the on-going use and evaluation of a variety of methods will be appropriate and beneficial for quite a few years.

Appendix A--Items from the
COMPREHENSIVE CHILD HISTORY AND FOOD INTAKE RECORD
(Minnesota Department of Health, 1978)

SPECIAL HEALTH CARE

__My child has undergone special tests for health problems.
__My child has been seen by medical specialists.
__My child has had some chronic health problems. If so, describe:

__There are or may be inherited diseases in our family (parents, brothers, sisters, grandparents, cousins, aunts and uncles) that may affect my child's health.

GROWTH AND DEVELOPMENT

List your child's age when he/she could do the following:

_____Sit alone
_____Walk alone
_____Say single words
_____Use two word sentences
_____Become toilet-trained

Please describe any questions or concerns you may have about your child's growth and development:

PRESENT MEDICAL HISTORY

Describe any medications your child takes reularly:

Describe any physcial limitations or restrictions your child has:

General

Check the appropriate box if you have any of the following concerns about your child:

__has a poor appetite
__eats too much
__has excessive thirst
__has sleep problems
__has too much energy
__has too little energy

Urinary

__My child complains of pain upon urination.
__I have noticed a strong or unusual odor from my child's urine.
__My child is not toilet trained.
__My child has trouble with bedwetting.
__My child has trouble wetting during the day.
__My child has had a kidney or bladder infection.

BEHAVIOR

Check the appropriate line if you have any concerns about the following behaviors in your child:

__bad dreams
__biting nails
__thumbsucking
__restlessness
__breath holding
__jealousy
__lying
__disobedient
__anger
__glum, sulky, moody
__bad temper
__stammering, stuttering, poor speech
__irritable, easily upset
__nervous habits of any kind
__poor bowel control
__clumsy and awkward
__destroys things on purpose
__selfish, unable to share
__contrary, stubborn, uncooperative
__feelings hurt easily
__daydreams, seems preoccupied
__wants too much attention, support or comfort

Other concerns:

Appendix B

Emotional Adjustment Screening Criteria

Stage I.

If any one of the following conditions are met, proceed to Stage II.

1. History

   a. Either one of the parents or the child has received mental health services.

   b. Single parent family.

   c. Current enuresis.

   d. Four or more concerns checked yes on the Behavioral portion of the child health history questionnaire (exluding feelings hurt easily item).

2. Dial behavioral observations--Three or more different behaviors circled.

3. Observation by speech clinician of autistic-like speech patterns.

4. Observation by nurse or physician of significant inappropriate emotional behavior.

5. Specific concern expressed by the child's parent regarding the child's emotional behavior.

Stage II.

Review concerns surfaced with the parent and if parent and interviewer agree or if parent requests so, refer for assessment.

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